



General Assembly

January Session, 2009

Amendment

LCO No. **5693**

SB0004605693SD0

Offered by:

SEN. WILLIAMS, 29th Dist.

SEN. LOONEY, 11th Dist.

SEN. GAFFEY, 13th Dist.

SEN. HANDLEY, 4th Dist.

SEN. MCDONALD, 27th Dist.

SEN. STILLMAN, 20th Dist.

SEN. SLOSSBERG, 14th Dist.

SEN. CRISCO, 17th Dist.

To: Subst. Senate Bill No. **46**

File No. 236

Cal. No. 223

"AN ACT CONCERNING THE CONSUMER REPORT CARD."

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- 1 In line 3, before "March" insert an opening bracket, and before "15"
- 2 strike the opening bracket
- 3 In line 3, before "fifteenth" insert "October"
- 4 In line 45, after "act," insert "as of January first of the year in which
- 5 such application is provided,"
- 6 After the last section, add the following and renumber sections and
- 7 internal references accordingly:
- 8 "Sec. 501. Subsection (a) of section 38a-478c of the general statutes is
- 9 repealed and the following is substituted in lieu thereof (*Effective*
- 10 *October 1, 2009*):
- 11 (a) On or before May [1, 1998, and annually thereafter] first of each

12 year, each managed care organization shall submit to the
13 commissioner:

14 (1) A report on its quality assurance plan that includes, but is not
15 limited to, information on complaints related to providers and quality
16 of care, on decisions related to patient requests for coverage and on
17 prior authorization statistics. Statistical information shall be submitted
18 in a manner permitting comparison across plans and shall include, but
19 not be limited to: (A) The ratio of the number of complaints received to
20 the number of enrollees; (B) a summary of the complaints received
21 related to providers and delivery of care or services and the action
22 taken on the complaint; (C) the ratio of the number of prior
23 authorizations denied to the number of prior authorizations requested;
24 (D) the number of utilization review determinations made by or on
25 behalf of a managed care organization not to certify an admission,
26 service, procedure or extension of stay, and the denials upheld and
27 reversed on appeal within the managed care organization's utilization
28 review procedure; (E) the percentage of those employers or groups
29 that renew their contracts within the previous twelve months; and (F)
30 notwithstanding the provisions of this subsection, on or before July 1,
31 1998, and annually thereafter, all data required by the National
32 Committee for Quality Assurance (NCQA) for its Health Plan
33 Employer Data and Information Set (HEDIS). If an organization does
34 not provide information for the National Committee for Quality
35 Assurance for its Health Plan Employer Data and Information Set, then
36 it shall provide such other equivalent data as the commissioner may
37 require by regulations adopted in accordance with the provisions of
38 chapter 54. The commissioner shall find that the requirements of this
39 subdivision have been met if the managed care plan has received a
40 one-year or higher level of accreditation by the National Committee for
41 Quality Assurance and has submitted the Health Plan Employee Data
42 Information Set data required by subparagraph (F) of this subdivision.

43 (2) A model contract that contains the provisions currently in force
44 in contracts between the managed care organization and preferred
45 provider networks in this state, and the managed care organization

46 and participating providers in this state and, upon the commissioner's
47 request, a copy of any individual contracts between such parties,
48 provided the contract may withhold or redact proprietary fee schedule
49 information.

50 (3) A written statement of the types of financial arrangements or
51 contractual provisions that the managed care organization has with
52 hospitals, utilization review companies, physicians, preferred provider
53 networks and any other health care providers including, but not
54 limited to, compensation based on a fee-for-service arrangement, a
55 risk-sharing arrangement or a capitated risk arrangement.

56 (4) Such information as the commissioner deems necessary to
57 complete the consumer report card required pursuant to section 38a-
58 478l. Such information may include, but need not be limited to: (A) The
59 organization's characteristics, including its model, its profit or
60 nonprofit status, its address and telephone number, the length of time
61 it has been licensed in this and any other state, its number of enrollees
62 and whether it has received any national or regional accreditation; (B)
63 a summary of the information required by subdivision (3) of this
64 section, including any change in a plan's rates over the prior three
65 years, its medical loss ratio, [or percentage of the total premium
66 revenues spent on medical care compared to administrative costs and
67 plan marketing] as defined in subsection (b) of section 38a-478l, as
68 amended by this act, how it compensates health care providers and its
69 premium level; (C) a description of services, the number of primary
70 care physicians and specialists, the number and nature of participating
71 preferred provider networks and the distribution and number of
72 hospitals, by county; (D) utilization review information, including the
73 name or source of any established medical protocols and the utilization
74 review standards; (E) medical management information, including the
75 provider-to-patient ratio by primary care provider and speciality care
76 provider, the percentage of primary and speciality care providers who
77 are board certified, and how the medical protocols incorporate input as
78 required in section 38a-478e; (F) the quality assurance information
79 required to be submitted under the provisions of subdivision (1) of

80 subsection (a) of this section; (G) the status of the organization's
81 compliance with the reporting requirements of this section; (H)
82 whether the organization markets to individuals and Medicare
83 recipients; (I) the number of hospital days per thousand enrollees; and
84 (J) the average length of hospital stays for specific procedures, as may
85 be requested by the commissioner.

86 (5) A summary of the procedures used by managed care
87 organizations to credential providers.

88 Sec. 502. Section 38a-478g of the general statutes is repealed and the
89 following is substituted in lieu thereof (*Effective October 1, 2009*):

90 (a) Each managed care contract delivered, issued for delivery,
91 renewed, amended or continued in this state [on or after October 1,
92 1997,] shall be in writing and a copy thereof furnished to the group
93 contract holder or individual contract holder, as appropriate. Each
94 such contract shall contain the following provisions: (1) Name and
95 address of the managed care organization; (2) eligibility requirements;
96 (3) a statement of copayments, deductibles or other out-of-pocket
97 expenses the enrollee must pay; (4) a statement of the nature of the
98 health care services, benefits or coverages to be furnished and the
99 period during which they will be furnished and, if there are any
100 services, benefits or coverages to be excepted, a detailed statement of
101 such exceptions; (5) a statement of terms and conditions upon which
102 the contract may be cancelled or otherwise terminated at the option of
103 either party; (6) claims procedures; (7) enrollee grievance procedures;
104 (8) continuation of coverage; (9) conversion; (10) extension of benefits,
105 if any; (11) subrogation, if any; (12) description of the service area, and
106 out-of-area benefits and services, if any; (13) a statement of the amount
107 the enrollee or others on his behalf must pay to the managed care
108 organization and the manner in which such amount is payable; (14) a
109 statement that the contract includes the endorsement thereon and
110 attached papers, if any, and contains the entire contract; (15) a
111 statement that no statement by the enrollee in his application for a
112 contract shall void the contract or be used in any legal proceeding

113 thereunder, unless such application or an exact copy thereof is
114 included in or attached to such contract; and (16) a statement of the
115 grace period for making any payment due under the contract, which
116 shall not be less than ten days. The commissioner may waive the
117 requirements of this subsection for any managed care organization
118 subject to the provisions of section 38a-182.

119 (b) Each managed care organization shall provide every enrollee
120 with a plan description. The plan description shall be in plain language
121 as commonly used by the enrollees and consistent with chapter 699a.
122 The plan description shall be made available to each enrollee and
123 potential enrollee prior to the enrollee's entering into the contract and
124 during any open enrollment period. The plan description shall not
125 contain provisions or statements that are inconsistent with the plan's
126 medical protocols. The plan description shall contain:

127 (1) A clear summary of the provisions set forth in subdivisions (1) to
128 (12), inclusive, of subsection (a) of this section, subdivision (3) of
129 subsection (a) of section 38a-478c and sections 38a-478j to 38a-478l,
130 inclusive;

131 (2) A statement of the number of managed care organization's
132 utilization review determinations not to certify an admission, service,
133 procedure or extension of stay, and the denials upheld and reversed on
134 appeal within the managed care organization's utilization review
135 procedure;

136 (3) A description of emergency services, the appropriate use of
137 emergency services, including to the use of E 9-1-1 telephone systems,
138 any cost sharing applicable to emergency services and the location of
139 emergency departments and other settings in which participating
140 physicians and hospitals provide emergency services and post
141 stabilization care;

142 (4) Coverage of the plans, including exclusions of specific
143 conditions, ailments or disorders;

- 144 (5) The use of drug formularies or any limits on the availability of
145 prescription drugs and the procedure for obtaining information on the
146 availability of specific drugs covered;
- 147 (6) The number, types and specialties and geographic distribution of
148 direct health care providers;
- 149 (7) Participating and nonparticipating provider reimbursement
150 procedure;
- 151 (8) Preauthorization and utilization review requirements and
152 procedures, internal grievance procedures and internal and external
153 complaint procedures;
- 154 (9) The medical loss ratio, [or percentage of total premium revenue
155 spent on medical care compared to administrative costs and plan
156 marketing] as defined in subsection (b) of section 38a-478l, as amended
157 by this act;
- 158 (10) The plan's for-profit, nonprofit incorporation and ownership
159 status;
- 160 (11) Telephone numbers for obtaining further information,
161 including the procedure for enrollees to contact the organization
162 concerning coverage and benefits, claims grievance and complaint
163 procedures after normal business hours;
- 164 (12) How notification is provided to an enrollee when the plan is no
165 longer contracting with an enrollee's primary care provider;
- 166 (13) The procedures for obtaining referrals to specialists or for
167 consulting a physician other than the primary care physician;
- 168 (14) The status of the National Committee for Quality Assurance
169 (NCQA) accreditation;
- 170 (15) Enrollee satisfaction information; and
- 171 (16) Procedures for protecting the confidentiality of medical records

172 and other patient information."